Caring Together
Group Home Models

2019 Stakeholder Engagement Sessions

June 28, 2019

Agenda

- Welcome Back
- Feedback Summary on Intensive Tx Family Placement Models
- Data handout
- Group Home Discussion

Feedback Summary

- Strong endorsement of DMH adding Intensive Tx Family Placement to its service array.
- Family Residence model not endorsed. Would not meet the intense needs of DMH-involved youth.

Clarify goals of service and population to be served

- Reunification, independent living, and/or getting "unstuck" from residential are possible goals. Each drives a different program design.
- Need a strong assessment and comprehensive homestudy in order to ensure right match.
- Consider tiered system to reflect levels of clinical acuity and support.
- Would most likely be adolescent focused given ages of youth served in CT programs at DMH.

Feedback Summary

Program Components

- Case manager to support foster parent and youth; in the home multiple times/week
- Members of a team could include OT, psychiatry
- 1:1 or 1:2 ratio is the maximum
- Back up for foster parent in emergency
- Respite
- Overnight support, e.g., for a youth with intensive needs including sleep problems

Feedback Summary

Business Considerations

- To ensure availability, pay stipend to keep bed open (e.g., DYS)
- A ratio of approximately 8 beds for 4 kids required to ensure good match. Ratio shifts for larger programs, e.g., 25 beds for 18 kids.
- One Example: a program with 16 kids in 10 homes has to close because it is too small to be viable (@ DCF's rate)
- To be viable / affordable, a program must spread management/ administrative costs over other foster programs (e.g., those purchased by DYS, DCF). Cannot serve DMH only.
- Consider pairing with Continuum Programs. Could Continuum have a # of beds available? Use Continuum Wrap only to enhance supports to the home / youth.

Feedback Summary

Recruiting Qualified Foster Parents

- Current residential or IRTP staff might be ideal as foster parents
  - Allow for more robustly trained person, they have modeling/coaching/experience versus just training
- Provide flexibility re: whether parent can have a job or not
- Child-specific foster care might be ideal
- Use of Family Partners as foster parents
- Role of foster parent would be to partner with family/parent
- Employees versus foster parent – issue of salary/rate and health coverage
- Provide respite and support for foster parent
- Rate should be high enough to secure foster parent commitment

Areas for Feedback

Focus Areas of Improvement
1. Continuum
2. Family-based Placement
3. Group Home
4. Young Adult Programs
5. Clinical Interventions
6. Best Practices
7. Business Models
8. Performance Measures

- Clinical specialization / capacity
- Short-term use
- Respite
- MAP/ Nursing

Clinical Specialization / Capacity

What we've learned

- DMH has lost some of the clinical specialization that it had in the past
- "No right of refusal" led to generalized practice.
- Crisis trumps treatment

Design considerations

- Increasing the BH expertise of the workforce
- How can DMH and its contracted programs rebuild clinical capacity?
- What treatment models/ strategies should be established /supported?

Short-term Use: "STARR"

What we've learned

- Some DMH Areas like STARR
- DMH use overwhelmed by DCF needs

Design considerations

- Creating capacity for Diagnostic Assessment
- Creating capacity for "RR: Rapid Reunification"
- Can short-term use occur within a Group Home setting: benefits and challenges

Short-term Use: Planned Respite

What we've learned

- Has not been available at the levels anticipated or needed
- Absent dedicated respite beds, beds are used to meet other (longer-term stay) needs

Design considerations

- How do we secure capacity for Planned Respite
- Can respite use occur within a Group Home setting: benefits and challenges

Closing Remarks

- Debrief of Today's Meeting
- Outstanding Questions
- Next Meeting:
  - **Date: July 12**
  - **Topic**: **Clinical Interventions**